

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005022		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2012	
NAME OF PROVIDER OR SUPPLIER UNION HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1606 N SEVENTH ST TERRE HAUTE, IN 47804			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one State licensure complaint.</p> <p>Complaint # IN00108725 Unsubstantiated: lack of sufficient evidence.</p> <p>Facility #: 005022</p> <p>Date: 10-3-12</p> <p>Surveyor: Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Union Hospital was found in compliance with State Rules 410 IAC 15-1.5-6, Nursing services and 410 IAC 15-1.5-10, Utilization review and discharge planning services.</p> <p>QA: cloughlin 10/29/12</p>			S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1